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5 UNITED STATES DISTRICT COURT  
6 NORTHERN DISTRICT OF CALIFORNIA  
7

8 EDIN ADGUSTO CHACON,

No. C 05-4880 SI (pr)

9 Plaintiff,

**FINDINGS OF FACT AND  
CONCLUSIONS OF LAW; ORDER**

10 v.

11 D. GALLIAN, sergeant; et al.,

12 Defendants.  
13 \_\_\_\_\_/

14 Edin Adgusto Chacon filed this pro se civil rights action under 42 U.S.C. § 1983, alleging  
15 a claim for deliberate indifference to his medical needs and a state law claim for negligence. The  
16 parties did not demand a jury trial, and the action came on for trial before the court on December  
17 16-17, 2008. The court heard testimony, received exhibits and heard argument at trial. The  
18 court now makes the following findings of fact and conclusions of law.  
19

20 **FINDINGS OF FACT**

21 1. At the relevant time, January 19-22, 2005, Edin Chacon was a prisoner housed in  
22 the C-facility of the security housing unit ("SHU") at Pelican Bay State Prison. The C-facility  
23 of the SHU had about 500 prisoners in it. The SHU had the most restrictive conditions in the  
24 California prison system; in general, a SHU prisoner would not be allowed out of his cell except  
25 when the prison staff opened the door to the cell to let the prisoner go to a specific destination  
26 (e.g., exercise yard, shower, or medical appointment). Within the SHU the housing units were  
27 set up as pods, with two tiers of cells in each pod. A prisoner cannot see into another cell when  
28 he is in his cell because the cells in each pod all face the same direction. Prisoners the C-facility  
can communicate with each other by speaking or yelling.

1           2.       The medical facilities at Pelican Bay included a clinic in the SHU and an  
2 infirmary. (The parties referred to the latter facility interchangeably as the infirmary, the C.T.C.,  
3 and the emergency room. For clarity's sake, the court will refer to it as the infirmary.)

4           3.       In the SHU, medical technical assistants ("MTAs") distributed medicine to  
5 prisoners in the morning and evening. About 100 doses of medicine were distributed in the  
6 morning and about 75-100 doses were distributed in the evening to the C-facility during the  
7 relevant time. The procedure for distribution was that the MTA came to the pod door with a cart  
8 full of medicine, and the prisoners were let out of their cells one at a time to receive medicine  
9 at the pod door from the MTA.

10          4.       While standing at the pod door, an MTA could not see Chacon in his cell.

11          5.       For security purposes, an MTA was not supposed to enter the SHU pod unless  
12 accompanied by correctional officers.

13          6.       All medicine (including both prescription and over-the-counter medications) had  
14 to be ordered by prison staff physicians, and those orders were sent to the prison pharmacy to  
15 be filled. The pharmacy issued the medicine and had it ready for the MTA to dispense to the  
16 prisoners. The pharmacy provided a chart identifying which prisoners were to be given  
17 medicine.

18          7.       In the SHU, the normal procedure for a prisoner who returned from outpatient  
19 surgery was that the prisoner would be escorted by correctional staff to the infirmary, where his  
20 condition would be checked and any doctor's orders from the outside doctor would be re-ordered  
21 by a prison doctor. The reason for the re-ordering of an outside doctor's orders was that  
22 California correctional facilities had a policy that all medicine to be dispensed to a prisoner had  
23 to be pursuant to an order of a prison doctor.

24          8.       Michelle Edwards was a registered nurse who worked as a floater at Pelican Bay,  
25 filling in for nursing employees who were absent or on vacation. On January 19, she was the  
26 temporary clinical nurse for the SHU in the C-facility. She had been in that position for about  
27 three weeks, although she had worked at the prison for about 9-10 months and had been a  
28 registered nurse for many years.

1           9       Chacon had rectal bleeding and eventually was diagnosed as having internal  
2 hemorrhoids. On January 19, he was sent from Pelican Bay to Sutter Coast Hospital, where Dr.  
3 Polidore performed a hemorrhoidectomy. Chacon was returned to Pelican Bay that same day  
4 by about 1:00 p.m. with discharge instructions.

5           10.     The "discharge instructions for going home" form he received from Sutter Coast  
6 Hospital listed two medicines for Chacon: a stool softener to be taken daily for two weeks and  
7 Motrin "600 mg. every 6 hrs. as needed x 7 days." On the portion of the form regarding "care  
8 of wound and dressing," there were no marks; on the portion of the form regarding "diet," the  
9 box marked "no restrictions" was checked and the patient was instructed to increase fluid intake  
10 as well as fruits and vegetables. The form also instructed the patient to "call if: unrelieved pain,  
11 fever >101, excessive bleeding." The form did not instruct that the patient was to be provided  
12 with gauze pads, but Dr. Polidore told Chacon that he would receive them because he would be  
13 passing blood via the rectum for about a week and was to use the gauze to clean the area.

14           11.     Upon his return to the prison from his outpatient surgery, Chacon was not  
15 processed in compliance with the normal procedure, i.e., he was not taken to the infirmary.

16           12.     Instead, Chacon was taken to the SHU clinic where he saw nurse Edwards. The  
17 correctional officer escorting Chacon gave Dr. Polidore's discharge orders for Chacon to nurse  
18 Edwards.

19           13.     On January 19, nurse Edwards did not know the normal procedure for processing  
20 prisoners returning to the SHU from outpatient surgery.

21           14.     Nurse Edwards checked on Chacon's health and released him to his cell. She told  
22 him he would receive the medicine and gauze pads at the evening medicine distribution in his  
23 pod.

24           15.     Nurse Edwards took the discharge orders to the office of Dr. David, the physician  
25 for the SHU clinic. She placed the discharge orders on Dr. David's desk where there was other  
26 paperwork, and stated that the prisoner had just returned from surgery and these were his orders.  
27 She did not further converse with Dr. David, but thought Dr. David acknowledged receipt of the  
28 documents. Nurse Edwards left work about an hour later at the end of her shift.

1           16.     When nurse Edwards put the discharge orders on her desk, Dr. David was engaged  
2 in preparing progress notes and doctor's orders. That day, Dr. David did not re-order the  
3 medicine ordered by Dr. Polidore.

4           17.     There was no evidence that, as of January 19, nurse Edwards had taken any steps  
5 to learn the normal procedure for processing prisoners returning to the SHU from outpatient  
6 surgery. There was no evidence that nurse Edwards asked Dr. David on January 19 if the  
7 discharge orders were supposed to be left on Dr. David's desk.

8           18.     In March 2005, nurse Edwards learned of the normal procedure for processing  
9 prisoners returning from outpatient surgery.

10          19.     Defendant Victor Gorospe, a licensed vocational nurse, worked as an MTA at  
11 Pelican Bay in January 2005. He did the evening medicine distribution in the SHU C-facility  
12 on January 19.

13          20.     Frank Fernandez was a prisoner housed on the lower tier of the same pod where  
14 Chacon was housed on the upper tier. During January 2005, Fernandez was one of the many  
15 prisoners being let out of his cell and retrieving the medicine at the pod door.

16          21.     On January 19, Chacon asked Fernandez to ask the MTA if the MTA had the  
17 medicine and gauze pads for Chacon when the MTA was handing out medicine that evening.

18          22.     Fernandez asked MTA Gorospe during the evening medicine distribution on  
19 January 19 to check if Gorospe had medicine and gauze pads for Chacon that had been ordered  
20 in his discharge orders from outpatient surgery earlier that day.

21          23.     Fernandez told MTA Gorospe that Chacon was starting to have pain and bleeding.

22          24.     Chacon also yelled down to MTA Gorospe to inquire if Gorospe had the medicine  
23 that had been ordered in his discharge orders from outpatient surgery.

24          25.     MTA Gorospe checked his chart and determined that he did not have any medicine  
25 for Chacon. He told Chacon and Fernandez that he did not have any medicine for Chacon, and  
26 that he would check into the matter.

27          26.     MTA Gorospe did not have Chacon let out of his cell so MTA Gorospe could see  
28 him.

1           27.     MTA Gorospe did not have any gauze pads on the medicine cart and told the  
2 prisoners that. He later obtained gauze pads and put them in the control booth so someone could  
3 get them. When Gorospe returned with the gauze pads, he did not speak to Chacon or  
4 Fernandez. These gauze pads did not reach Chacon.

5           28.     After the medicine was distributed to the prisoners, Gorospe made further inquiry  
6 about Chacon's request for medicine. He called the infirmary and found that there were no  
7 orders for medicine for Chacon. He did not call the on-call doctor or ask a nurse at the infirmary  
8 for the medicine to be ordered that night.

9           29.     MTA Gorospe wrote a health care services request form and left it in the clinic for  
10 the morning shift to address. The form had Chacon's name and cell number on it and stated "I/M  
11 suppose [sic] to have received pain meds from hemorrhoidectomy procedure on 1/20/05."  
12 Although the form was dated January 20, it was written by Gorospe on the night of January 19,  
13 2005.

14           30.     There was no evidence that the form was reviewed on January 20. The form has  
15 a note indicating it was not addressed until January 21 at the earliest: an unidentified author  
16 wrote on the form "was scheduled 1-24-05 & meds ordered 1-21-05."

17           31.     Chacon did not receive Motrin, stool softener or gauze pads on January 19.

18           32.     By the morning of January 20, Chacon's pain was worse, and he was unable to  
19 urinate or have a bowel movement.

20           33.     Defendant Robert Munoz, a licensed vocational nurse, worked as an MTA at  
21 Pelican Bay in January 2005. He did the morning medicine distribution in the SHU C-facility  
22 on January 20.

23           34.     During the morning medicine distribution on January 20, Chacon and Fernandez  
24 asked MTA Munoz if he had the medicine and gauze pads for Chacon who had returned from  
25 outpatient surgery with discharge orders for them. Fernandez also told Munoz that Chacon was  
26 sick.

27           35.     MTA Munoz checked his chart, found that he had nothing listed for Chacon, told  
28 the prisoners that he had nothing listed for Chacon, and said he would check into the matter.

1           36.     MTA Munoz did not give gauze pads to Chacon. He did not have them on the  
2 medicine cart.

3           37.     MTA Munoz did not have Chacon released from his cell to view him and did not  
4 physically examine him.

5           38.     On January 20, MTA Munoz did not see the health care request form Gorospe had  
6 prepared and left in the clinic the previous night.

7           39.     During the evening medicine distribution on January 20 and the morning medicine  
8 distribution on January 21, non-defendant MTAs again had no medicine or gauze pads for  
9 Chacon, and promised to look into the matter. These MTAs had Chacon released from his cell  
10 and consulted with him.

11          40.     Meanwhile, Chacon prepared an inmate grievance on January 21, in which he  
12 explained that he had returned from outpatient surgery on January 19, and had not received the  
13 pain killers, gauze and stool softeners. The inmate appeal also stated that Chacon had been in  
14 severe pain, especially when having a bowel movement, and had been bleeding.

15          41.     Nurse Edwards responded to the inmate appeal the same day. In her response on  
16 January 21, Edwards wrote that the doctor would write the orders for Chacon's medicine and that  
17 Chacon was scheduled to be seen by a doctor early the next week.

18          42.     Dr. David ordered the medicine on January 21.

19          43.     Defendant Lloyd Goulter, a registered nurse, worked as an MTA at Pelican Bay  
20 in January 2005. He did the evening medicine distribution in the SHU C-facility on January 21.

21          44.     MTA Goulter provided Motrin, stool softeners and gauze pads to Chacon during  
22 the evening medicine distribution on January 21.

23          45.     Chacon told MTA Goulter he had feverish symptoms and pain, and had not  
24 received his medicine since his outpatient surgery on January 19.

25          46.     MTA Goulter believed that the medicine he gave to Chacon would address  
26 Chacon's complaints, and knew that Chacon had not received his medicine before then. MTA  
27 Goulter did not call a doctor when Chacon reported his feverish symptoms and pain because he  
28 was bringing medicine to Chacon that he thought would address Chacon's complaints. MTA

1 Goulter thought a doctor would tell him to give the medicine a chance to work.

2 47. During the evening and overnight, there were no doctors on site at the SHU. There  
3 was a doctor on call who could be contacted via a telephone. The doctors' shifts were from 8:00  
4 a.m. - 4:00 p.m. There were nurses in the infirmary during the evening and overnight.

5 48. None of the MTA defendants doubted Chacon was truthful in telling them that he  
6 had just had a hemorrhoidectomy outpatient surgery and that medicine and gauze pads had been  
7 ordered for him by the outside doctor.

8 49. On January 22, Chacon received his medicine during the morning distribution of  
9 medicine by the MTA.

10 50. Later on the morning of January 22, Chacon called out for help. He had been in  
11 severe pain and urinating blood, and was unable to have a bowel movement.

12 51. A correctional officer brought Chacon by wheelchair to the clinic.

13 52. At the clinic, MTA Munoz took Chacon's vital signs, and notified the infirmary  
14 that Chacon needed to go there. Chacon's temperature was recorded as 99.8 degrees.

15 53. Chacon was rushed to the infirmary. At the infirmary, Chacon was given pain  
16 medication, examined by a doctor, and treated for a urinary tract infection that had traveled to  
17 his kidneys. Chacon was in the infirmary for two days before being returned to his SHU cell.

18 54. Kenneth Hammerman, M.D., a gastroenterologist, testified as an expert witness  
19 for the defense after reviewing the medical records for Chacon. Dr. Hammerman opined that  
20 Chacon's infection was a consequence of the surgical procedure and that the failure to administer  
21 Motrin, stool softener, and gauze pads did not cause the infection. Dr. Hammerman opined that  
22 the infection was not due to stool blocking or being impacted in the rectum because a rectal  
23 exam on January 22 noted no stool in the rectum and noted no bleeding. The absence of stool  
24 softener did not matter with respect to the urinary tract infection because Chacon did not have  
25 stool in his rectum, and only stool located in the rectum (which is adjacent to the bladder and  
26 may push on it) would have mattered for purposes of determining the cause of the urinary tract  
27 infection. Dr. Hammerman explained that a hemorrhoidectomy surgery can traumatize the  
28 bladder due to the proximity of rectum and bladder, and the patient may have urinary retention

1 as a result. The urinary retention creates the urinary tract infection risk, and the infection can  
2 travel upstream in the urinary tract, e.g., to the kidneys. The problem was the blocked urine, and  
3 it was not a matter of fecal matter getting into the urinary tract. Dr. Hammerman also explained  
4 that, although Motrin is an anti-inflammatory agent and might have caused Chacon to have less  
5 inflammation, Chacon still would not have been able to urinate; therefore, one cannot say with  
6 certainty that he would not have developed a urinary tract infection if he had been given Motrin.  
7 The court finds Dr. Hammerman's testimony to be credible.

8 55. The kidney/urinary tract infection Chacon developed was not caused by the failure  
9 to provide him with Motrin, stool softener, or gauze pads.

10 56. Chacon was in more pain without the Motrin and stool softener than he would have  
11 been if he had received the Motrin and stool softener mentioned in Dr. Polidore's discharge  
12 instructions. Chacon was in more discomfort without the gauze pads than he would have been  
13 in if he had been provided with the gauze pads as directed by Dr. Polidore.

## 14 15 CONCLUSIONS OF LAW

16 1. The court has federal question jurisdiction to decide this action brought under 42  
17 U.S.C. § 1983. See 28 U.S.C. § 1331. The court has supplemental jurisdiction over the state  
18 law negligence claim. See 28 U.S.C. § 1367.

19 2. Venue is proper because the events giving rise to Chacon's claims occurred in Del  
20 Norte County, which is within the Northern District of California. 28 U.S.C. §§ 84(a), 1391(b).

21 3. To prevail on a claim under 42 U.S.C. § 1983, Chacon must show (1) that a right  
22 secured by the Constitution or laws of the United States was violated and (2) that the violation  
23 was committed by a person acting under the color of state law. See West v. Atkins, 487 U.S.  
24 42, 48 (1988).

25 4. All defendants were acting under color of state law as they interacted with Chacon.

26 5. Deliberate indifference to a prisoner's serious medical needs violates the Eighth  
27 Amendment's proscription against cruel and unusual punishment. See Estelle v. Gamble, 429  
28 U.S. 97, 102-04 (1975). To prove that the response of prison officials to a prisoner's medical

1 need was constitutionally deficient, the prisoner must establish (1) a serious medical need and  
2 (2) deliberate indifference to that need by prison officials. See McGuckin v. Smith, 974 F.2d  
3 1050, 1059-60 (9th Cir. 1992), overruled on other grounds, WMX Technologies, Inc. v. Miller,  
4 104 F.3d 1133, 1136 (9th Cir. 1997) (en banc).

5 6. "A 'serious' medical need exists if the failure to treat a prisoner's condition could  
6 result in further significant injury or the 'unnecessary and wanton infliction of pain.'" Id. at  
7 1059 (quoting Estelle, 429 U.S. at 104). A prison official exhibits deliberate indifference when  
8 he or she knows of and disregards a substantial risk of serious harm to prisoner health by failing  
9 to take reasonable measures to abate it. See Farmer v. Brennan, 511 U.S. 825, 837 (1994). The  
10 official must both know of "facts from which the inference could be drawn" that an excessive  
11 risk of harm exists, and he or she must actually draw that inference. Id.

12 7. Chacon's post-surgery need for Motrin, stool softener and gauze pads was a serious  
13 medical need.

14 8. None of the defendants acted with deliberate indifference to Chacon's serious  
15 medical need. Each defendant took some positive steps to attempt address Chacon's request for  
16 Motrin, stool softener and gauze pads.

17 9. "[N]egligence is conduct which falls below the standard established by law for the  
18 protection of others against unreasonable risk of harm.' . . . Thus, as a general proposition one 'is  
19 required to exercise the care that a person of ordinary prudence would exercise under the  
20 circumstances.' . . . Because application of this principle is inherently situational, the amount of  
21 care deemed reasonable in any particular case will vary, while at the same time the standard of  
22 conduct itself remains constant, i.e., due care commensurate with the risk posed by the conduct  
23 taking into consideration all relevant circumstances." Flowers v. Torrance Mem. Hosp. Med.  
24 Center, 8 Cal. 4th 992, 997 (Cal. 1994) (citations omitted). Professionals, by virtue of their  
25 training and education in their professions, do not have a higher duty of care, but instead their  
26 training and education are circumstances relevant to the overall assessment of what constitutes  
27 ordinary prudence in the situation they confront. See id. at 997-98.

28 10. In a medical malpractice case in California, expert testimony is necessary to

1 provide the standard of care for a practitioner of the kind of medicine at issue. See Flowers, 8  
2 Cal. 4th at 1001. However, expert testimony is not necessary when the conduct required by the  
3 particular circumstances is within the common knowledge of lay persons. Id.

4 11. The court rejects defendants' argument that plaintiff's negligence claim must fail  
5 because he offered no expert testimony to establish the standard of care for medical care  
6 providers. The medical care issue here was the provision of medicine and gauze pads that had  
7 been ordered by the treating surgeon. The way Pelican Bay staff members implemented those  
8 orders had far more to do with prison policies than medical care standards. An expert nurse or  
9 doctor would have been unable to offer a relevant opinion in this case because the issue was not  
10 a matter of medical judgment but instead a matter of prison operations. If one stripped away the  
11 prison setting, the question here would be whether nurses and technicians were free to ignore  
12 a doctor's discharge orders – a question as to which the common-sense answer is "no." No  
13 expert testimony was required on that point as it was within the common experience of lay  
14 persons. See generally Miller v. Los Angeles County Flood Control Dist., 8 Cal. 3d 689, 702  
15 (Cal. 1973). Rather than being a question of professional judgment in the provision of medical  
16 care, this case is much more about the behavior of employees in large organizations with a  
17 division of labor. An expert is not needed to determine whether there is negligence in such an  
18 employee's response when a customer needs service and is wholly dependent on workers in the  
19 organization for services – whether it be an office worker stuck in an elevator trying to get  
20 someone to get him out, or a bank customer trying to get a bank to fix its bookkeeping error, or  
21 a prisoner trying to get his outside medical orders recognized and implemented by prison staff.  
22 The steps a reasonable front-line worker should take to resolve a situation where a customer  
23 alerts the worker to the fact that something is amiss – that the elevator is stuck, that the bank  
24 balance is wrong, or that the medical orders have not been implemented – do not require expert  
25 testimony. As to the nurse's mistake, learning office procedures and following them is not a  
26 matter of professional medical judgment and is not beyond the ken of laypersons.

27 12. Michelle Edwards was negligent in her handling of Chacon's discharge orders on  
28 his return from outpatient surgery. She was negligent in failing to inform herself of the normal

1 procedure for processing a prisoner returning from outpatient surgery and in not checking with  
2 Dr. David to be sure the discharge orders were re-ordered by Dr. David. Where, as at Pelican  
3 Bay, there is a division of labor in the organization, a prudent person would inform herself of  
4 the standard operating procedures and comply with them, or would make inquiry to determine  
5 whether her selected course of action (leaving orders in someone's in-box) would result in the  
6 desired outcome (having those orders entered into the prison medical care system). Her  
7 negligence caused the pain, suffering and discomfort that Chacon experienced the next couple  
8 of days due to not receiving the Motrin, stool softener, and gauze pads in a timely manner.

9 13. Michelle Edwards was not negligent in her response to Chacon's inmate appeal.

10 14. Victor Gorospe was negligent in his response to Chacon's request for medicine and  
11 supplies. Although Gorospe made a call to inquire after the medicine and left a note for the next  
12 shift to check into the matter, Gorospe was negligent in not taking further steps to find out what  
13 had become of the discharge orders which he did not doubt existed but which he could not find  
14 in the Pelican Bay system. Gorospe also was negligent in not having Chacon let out of his cell  
15 to visually evaluate him in light of the information that Chacon and Fernandez provided about  
16 Chacon's condition and need for medicine. Gorospe also was negligent in not ensuring that the  
17 gauze pads that he did retrieve were delivered to the patient rather than left in the control booth.  
18 His negligence caused the pain, suffering and discomfort that Chacon experienced the next  
19 couple of days due to not receiving the Motrin, stool softener, and gauze pads in a timely  
20 manner.

21 15. Robert Munoz was negligent in his response to Chacon's request for medicine and  
22 supplies on January 20. Munoz was negligent in not having Chacon let out of his cell to visually  
23 evaluate him in light of the information that Chacon and Fernandez provided about Chacon's  
24 condition and need for medicine. Munoz was negligent in not making further inquiries to  
25 determine why Chacon's discharge orders had not made it into Pelican Bay's medical information  
26 system or calling a doctor to have those orders written. His negligence caused the pain, suffering  
27 and discomfort that Chacon experienced that and the next day due to not receiving the Motrin,  
28 stool softener, and gauze pads.

